U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 30 May 2006

Case No. 2004-BLA-5852

In the Matter of:
JOE BARRETT,
Claimant,

v.

SHAMROCK COAL CO., INC.
c/o JAMES RIVER COAL CO.,
Employer,
and
SELF-INSURED: SUN COAL, INC.,
c/o ACORDIA EMPLOYERS SERVICE,
Carrier,

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,
Party in Interest.

APPEARANCES:
John Hunt Morgan, Esq.
On behalf of Claimant

Lois A. Kitts, Esq.
On behalf of Employer/Carrier

BEFORE: Thomas F. Phalen, Jr.
Administrative Law Judge

DECISION AND ORDER – DENIAL OF BENEFITS

This is a decision and order arising out of a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1977, 30 U.S.C. §§ 901-962, ("the Act") and the regulations thereunder, located in Title 20 of

the Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order refer to sections of that Title.[1]

On February 18, 2004, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs, for a hearing. (DX 43).[2] A formal hearing on this matter was conducted on May 25, 2005, in Hazard, Kentucky, by the undersigned Administrative Law Judge. All parties were afforded the opportunity to call and to examine and cross examine witnesses, and to present evidence, as provided in the Act and the above referenced regulations.

ISSUES[3]

The issues in this case are:

1. Whether the claim was timely filed;

2. Whether the Claimant had pneumoconiosis as defined by the Act and the regulations;

3. Whether the Claimant's pneumoconiosis arose out of coal mine employment;

4. Whether Claimant's disability was due to pneumoconiosis; and

5. Whether the Claimant has established a material change in conditions per §725.309(c),(d).

(DX 43).

Based upon a thorough analysis of the entire record in this case, with due consideration accorded to the arguments of the parties, applicable statutory provisions, regulations, and relevant case law, I hereby make the following:

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[1] The Department of Labor amended the regulations implementing the Federal Coal Mine Health and Safety Act of 1969, as amended. These regulations became effective on January 19, 2001, and are found at 65 Fed. Reg. 80, 045-80,107 (2000)(to be codified at 20 C.F.R. Parts 718, 722, 725 and 726). On August 9, 2001, the United States District Court for the District of Columbia issued a Memorandum and Order upholding the validity of the new regulations. All citations to the regulations, unless otherwise noted, refer to the amended regulations.

[2] In this Decision, "DX" refers to the Director's Exhibits, "EX" refers to the Employer's Exhibits, "CX" refers to the Claimant's Exhibits, and "Tr." refers to the official transcript of this proceeding.

[3] At the hearing, Employer withdrew as uncontested the following issues: whether the person upon whose disability the claim is based is a miner; whether the miner worked as a miner after December 31, 1969; whether the Claimant worked at least 16 years in or around one or more coal mines; whether Claimant was totally disabled; whether Claimant has one dependent for purpose of augmentation; whether the named employer is the responsible operator; whether the named employer has secured the payment of benefits; and whether the miner's most recent period of cumulative employment of not less than one year was with the named Responsible Operator. (Tr. 8-9). Additionally, Employer listed other issues that will not be decided by the undersigned; however, they are preserved for appeal. (DX 44 Item 18(B and C).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background

Joe Barrett ("Claimant") was born on August 19, 1931 and he was 73 years-old at the time of the hearing. (DX 2). He completed the fifth grade. (DX 2). In 1967, he married Betsy Collett. (DX 2, 6). They do not live together and he is not under a court order to make support payments. (DX 2). Also, he does not have any dependent children. (DX 2). The parties, however, stipulated to one dependent for purpose of augmentation. (Tr. 8-9).

On his application for benefits, Claimant alleged that he engaged in underground coal mine employment for 16 years. (DX 2). Claimant last worked on the belt lines as a rock duster and shoveling coal. (DX 4). This position required that he stand for eight to twelve hours per day and lift 50 to 75 pounds several times per day. (DX 4). Claimant last worked in and around coal mines in 1988, when he quit due to health problems. (DX 2).

Procedural History

Claimant filed his initial claim for benefits under the Act on September 18, 1992 (DX 1). This claim was denied by the District Director, Officer of Workers' Compensation on May 18, 1993. The matter was transferred to the Office of Administrative Law Judges, and on April 21, 1994, Administrative Law Judge O'Neill issued a decision and order – denial of benefits, finding that Claimant had failed to satisfy any of the elements of entitlement. Claimant appealed, and on January 24, 1995, the Benefits Review Board affirmed Judge O'Neill's denial of benefits.

Claimant requested a modification by submission of additional evidence on February 23, 1995. The Director reviewed the evidence and issued a proposed order denying benefits on September 26, 1995. A formal hearing was held, and on November 26, 1996, Judge O'Neill issued a decision and order on modification denying benefits. Claimant submitted a timely appeal, and on November 24, 1997, the Board again affirmed Judge O'Neill's denial of benefits.

On July 6, 2001, Claimant filed the instant claim for benefits under the Act. (DX 2). The Director issued a proposed decision and order – denial of benefits on February 10, 2003. (DX 27). On February 20, 2003, Claimant timely requested a formal hearing before the Office of Administrative Law Judges. (DX 28). The matter was ultimately transferred to this office on February 18, 2004. (DX 44).

Timeliness

Under § 725.308(a), a claim of a living miner is timely filed if it is filed "within three years after a medical determination of total disability due to pneumoconiosis" has been communicated to the miner. Section 725.308(c) creates a rebuttable presumption that every claim for benefits is timely filed. This statute of limitations does not begin to run until a miner is actually diagnosed by a doctor, regardless of whether the miner believes he has the disease earlier. *Tennessee Consolidated Coal Company v. Kirk*, 264 F.3d 602 (6th Cir. 2001). In addition, the court stated:

> The three-year limitations clock begins to tick the first time that a miner is told by a physician that he is totally disabled by pneumoconiosis. This clock is not stopped by the resolution of a miner's claim or claims, and, pursuant to *Sharondale*, the clock may only be turned back if the miner returns to the mines after a denial of benefits. There is thus a distinction between premature claims that are unsupported by a medical determination, like Kirk's 1979, 1985, and 1988 claims, and those claims that come with or acquire such support. Medically supported claims, even if ultimately deemed "premature" because the weight of the evidence does not support the elements of the miner's claim, are effective to begin the statutory period. [Footnote omitted.] Three years after such a determination, a miner who has not subsequently worked in the mines will be unable to file any further claims against his employer, although, of course, he may continue to pursue pending claims.

Id.

In an unpublished opinion arising in the Sixth Circuit, *Furgerson v. Jericol Mining, Inc.*, BRB Nos. 03-0798 BLA and 03-0798 BLA-A (Sept. 20, 2004) (unpub.), the Benefits Review Board held that *Kirk*, 264 F.3d 602 is controlling and directed the administrative law judge in that case to "determine if [the physician] rendered a well-reasoned diagnosis of total disability due to pneumoconiosis such that his report constitutes a 'medical determination of total disability due to pneumoconiosis which has been communicated to the miner'" under § 725.308 of the regulations.

Employer's brief cites Dr. Varghese's February 13, 1995 letter (DX 10) for the proposition that a diagnosis of total disability due to pneumoconiosis was communicated to Claimant more than three years prior to the instant application for benefits under the Act. (Er. Br. at 18). Dr. Varghese's report stated that Claimant was disabled due to black lung and emphysema. He based this conclusion on history to dust exposure (15 years of coal mine employment), symptomatology (cough and difficulty breathing), physical examination (bilateral emphysema), chest x-ray (bilateral emphysema), and a notation that claimant is "getting treatment for pulmonary emphysema probably from black lung."

An opinion may be given little weight if it is equivocal or vague. *Island Creek Coal Co. v. Holdman*, 202 F.3d 873 (6th Cir. 2000) (a physician, who concluded that simple pneumoconiosis "probably"' would not disrupt a miner's pulmonary function, was equivocal and insufficient to "rule out" causal nexus as required by 20 C.F.R. §727.203(b)(3)); *Griffith v. Director, OWCP*, 49 F.3d 184 (6th Cir. 1995) (treating physician's opinion entitled to little weight where he concluded that the miner "probably" had black lung disease). As a result, since Dr. Varghese stated that Claimant's emphysema was "probably from black lung," I find his opinion to be equivocal, and thus, poorly reasoned. In addition, since he fails to specify the x-ray he considered in reach this conclusion, I find his opinion to be insufficiently documented. Considering Dr. Varghese's report as a whole, I find that it is not well-reasoned or well-documented, and thus, insufficient for the purpose of proving that Claimant was totally disabled due to pneumoconiosis. Therefore, I find that Dr. Varghese's report does not satisfy the requirements of *Furgerson.*

Next, Employer contends that since Claimant submitted Dr. Varghese medical report, the communication requirement is satisfied. I am also not inclined to assume that simply because a medical report was in the record or in the possession of Claimant's attorney, that the findings were "communicated" to Claimant. In fact, the presumption under §725.308(c) is that every claim is timely. Assuming that access to a report equates to communication by a physician would severely undermine §725.308(c).

Concerning timeliness, I have found that Dr. Varghese's report is not a well-reasoned opinion diagnosing total disability due to pneumoconiosis. In addition, I have found that such a diagnosis was never communicated to Claimant. Either of these findings is independently sufficient to defeat Employer's timeliness contention, thus, I find that this claim was timely filed.

Length of Coal Mine Employment

On his application for benefits, Claimant stated that he engaged in coal mine employment for 16 years. (DX 2). The Director also determined that Claimant has at least 16 years of coal mine employment. (DX 27). The parties have stipulated that the Claimant worked at least 16 years in or around one or more coal mines. (Tr. 8-9). I find that the record supports this stipulation, (DX 3-5), and therefore, I hold that the Claimant worked at least 16 years in or around one or more coal mines.

Claimant's last employment was in the Commonwealth of Kentucky (DX 3,17); therefore, the law of the Sixth Circuit is controlling.[4]

Responsible Operator

Liability under the Act is assessed against the most recent operator which meets the requirements of §§ 725.494 and 725.495. The District Director identified Shamrock Coal Co., Inc. as the putative responsible operator due to the fact that it was the last company to employ Claimant for a full year. (DX 17, 34). Employer does not contest its designation as responsible operator. (DX 35; Tr. 8-9). Therefore, I find that Shamrock Coal Co., Inc. is properly designated as the responsible operator in this case.

NEWLY SUBMITTED MEDICAL EVIDENCE

Section 718.101(b) requires any clinical test or examination to be in substantial compliance with the applicable standard in order to constitute evidence of the fact for which it is proffered. *See* §§ 718.102 - 718.107. The claimant and responsible operator are entitled to submit, in support of their affirmative cases, no more than two chest x-ray interpretations, the results of no more than two pulmonary function tests, the results of no more than two blood gas studies, no more than one report of each biopsy, and no more than two medical reports. §§ 725.414(a)(2)(i) and (3)(i). Any chest x-ray interpretations, pulmonary function studies, blood gas studies, biopsy report, and physician's opinions that appear in a medical report must each be

[4] Appellate jurisdiction with a federal circuit court of appeals lies in the circuit where the miner last engaged in coal mine employment, regardless of the location of the responsible operator. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200 (1989)(en banc).

admissible under § 725.414(a)(2)(i) and (3)(i) or § 725.414(a)(4). §§ 725.414(a)(2)(i) and (3)(i). Each party shall also be entitled to submit, in rebuttal of the case presented by the opposing party, no more than one physician's interpretation of each chest x-ray, pulmonary function test, arterial blood gas study, or biopsy submitted, as appropriate, under paragraphs (a)(2)(i), (a)(3)(i), or (a)(3)(iii). §§ 725.414(a)(2)(ii), (a)(3)(ii), and (a)(3)(iii). Notwithstanding the limitations of §§ 725.414(a)(2) or (a)(3), any record of a miner's hospitalization for a respiratory or pulmonary or related disease, or medical treatment for a respiratory or pulmonary or related disease, may be received into evidence. § 725.414(a)(4). The results of the complete pulmonary examination shall not be counted as evidence submitted by the miner under § 725.414. § 725.406(b).

Claimant selected Dr. Glen Baker to provide his Department of Labor sponsored complete pulmonary examination. (DX 7). Dr. Baker conducted the examination on December 20, 2001. I admit Dr. Baker's report under § 725.406(b).

Claimant completed a Black Lung Benefits Act Evidence Summary Form, but he did not designate any evidence beyond Dr. Baker's DOL sponsored examination. (CX 2). Claimant's evidence complies with the requisite quality standards of §§ 718.102-107 and the limitations of § 725.414(a)(3). Therefore, I admit Claimant's designated evidence.

Employer completed a Black Lung Benefits Act Evidence Summary Form. Employer designated the interpretation of the August 27, 2002 x-ray by Drs. Broudy and West as initial evidence, and Dr. Scott's reading of the September 14, 2001 film as rebuttal evidence. Employer also designated Dr. Broudy's August 27, 2002 medical report and supporting deposition and Dr. Vuskovich's March 28, 2005 report as initial evidence. Next, Employer designated Dr. Wheeler's February 26, 2001 and February 20, 2001 CT scan interpretations. Finally, Employer submitted a variety of hospitalization records. I find that Employer's evidence complies with the requisite quality standards of §§ 718.102-107 and the limitations of § 725.414(a)(3). Thus, I admit Employer's designated evidence.

X-RAYS

Exhibit	Date of X-ray	Date of Reading	Physician / Credentials	Interpretation
DX 8	9/14/01	1/24/02	Baker, B-reader[5]	1/0 pq
DX 24	9/14/01	8/10/02	Scott, BCR[6], B-reader	Negative
DX 25	8/27/02	8/27/02	Broudy, B-reader	Negative
DX 26	8/27/02	8/29/02	West	No diagnosis[7]

[5] A "B" reader is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successful completion of an examination conducted by or on behalf of the Department of Health and Human Services. This is a matter of public record at HHS National Institute for Occupational Safety and Health reviewing facility at Morgantown, West Virginia. (42 C.F.R. § 37.5l) Consequently, greater weight is given to a diagnosis by a "B" Reader. *See Blackburn v. Director, OWCP*, 2 B.L.R. 1-153 (1979).

[6] A physician who has been certified in radiology or diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Association. *See* 20 C.F.R. § 727.206(b)(2)(III). The qualifications of physicians are a matter of public record at the National Institute of Occupational Safety and Health reviewing facility at Morgantown, West Virginia.

ARTERIAL BLOOD GAS STUDIES

Exhibit	Date	pCO_2	pO_2	Qualifying
DX 12	2/20/01	40	104	No
DX 12	2/20/01	41	111	No
DX 12	2/22/01	38	88	No
DX 12	2/23/01	40	68	No
DX 12	2/24/01	38	67	No
DX 12	2/26/01	37	59	Yes
DX 12	2/26/01	53	67	Yes
DX 12	2/27/01	41	69	No
DX 13	2/28/01	56.6	62.3	Yes
DX 12	2/28/01	42	82	No
DX 12	3/01/01	40	123	No
DX 12	3/02/01	41	62	No
DX 12	3/03/01	38	72	No
DX 12	3/04/01	42	86	No
DX 12	3/06/01	39	70	No
DX 12	3/07/01	39	76	No
DX 12	3/09/01	37	112	No
DX 12	6/10/01	56	105	Yes
DX 12	6/11/01	55	53	Yes
DX 12	6/12/01	50	76	Yes
DX 12	6/13/01	67	111	Yes
DX 12	6/14/01	56	105	Yes
DX 25	8/12/02	50	85	Yes[8]

All values are pre-exercise

Narrative Reports

Dr. Glen Baker, an internist, pulmonologist, and B-reader (CX 1), examined Claimant on December 20, 2001, and submitted a medical report. (DX 8). Dr. Baker noted that he was unable to conduct any testing because Claimant was "essentially paralyzed." Dr. Baker considered the following: symptomatology (sputum, wheezing, dyspnea, and cough), employment history (approximately 15 years of underground coal mine employment), individual history (pneumonia, attacks of wheezing, chronic bronchitis, high blood pressure, amyotropic lateral sclerosis ("ALS"), tracheotomy in 2001, and several episodes for respiratory failure in the last eight to nine months requiring several hospitalizations and continuous ventilatory support), smoking history (never smoked), physical examination (no findings noted), and a chest x-ray (a September 14, 2001 film read as 1/0). Dr. Baker diagnosed CWP based solely on the x-ray and Claimant's exposure to coal dust. He also diagnosed chronic respiratory failure secondary to

[7] Dr. West stated that there was a patch of infiltrate in the right base with some pleural reaction, but there was no CHF or other change noted. However, he did not state whether Claimant suffered from CWP.

[8] Dr. Broudy stated that this study revealed that Claimant suffered from chronic respiratory failure, but he noted that Claimant was on supplemental oxygen at the time of testing.

ALS. However, he was unable to attribute this condition to any specific cause. Dr. Baker opined that Claimant was severely impaired due to his ALS with neuromuscular paralysis, and thus does not retain the respiratory capacity to perform the work of an underground coal miner or to do similarly arduous manual labor in a dust-free environment.

Dr. Bruce Broudy, an internist, pulmonologist, and B-reader, examined Claimant on August 27, 2002 and submitted a report. (DX 25). Dr. Broudy explained that Claimant is chronically hospitalized due to chronic ventilatory failure caused by ALS, which leaves him on a ventilator. Also, he was unable to give a history or take a PFT because of a tracheostomy tube, and since he was on a ventilator, there was little point in performing an ABG. In addition, since he is unable to stand and bear weight, a single AP view of the chest was obtained. Dr. Broudy considered the following: symptomatology (chronic cough, sputum, occasional shortness of breath, and dyspnea on exertion), employment history (15 ½ years in underground mining as a general laborer and rock duster), individual history (respiratory failure in 2001 due to ALS and has been on a ventilator), smoking history (none), physical examination (quiet with no adventitial sounds), chest x-ray (0/0), and an ABG (conducted on 8/12/02 revealed PCO2 50/PO2 85). Dr. Broudy diagnosed chronic respiratory failure due to ALS. He opined that Claimant is totally disabled due to respiratory failure caused by the progressive neuromuscular disease ALS, but there is no causal connection between this disability and coal mine employment, nor does pneumoconiosis contribute to this respiratory disability. Dr. Broudy concluded that there is no evidence that Claimant suffers from pneumoconiosis or that his occupation as a coal miner contributed to his pulmonary disability.

Dr. Broudy was deposed by the Employer on May 12, 2005, when he repeated the findings of his earlier written report. (EX 1). He added that there is no known cause of ALS. In preparation for this deposition, Dr. Broudy also had an opportunity to review the treatment notes of record. Based on all of this medical documentation, in conjunction with his previous report, Dr. Broudy reiterated that Claimant was totally disabled, but that this condition was unrelated to coal dust exposure, and that there was no evidence of CWP.

Dr. Matthew Vuskovich, a B-reader and Board certified in occupational medicine, conducted a medical evidence review and submitted a report on March 28, 2006. (EX 2). In addition to the evidence from the previous claim, Dr. Vuskovich considered the following: Dr. Baker's December 20, 2001 report, Dr. Broudy's August 27, 2002 report, the 2001 CT scans, and the newly submitted treatment records. Also, Dr. Vuskovich based his opinion on employment history (15 years of underground coal mine employment as a roof bolter, track motor operator, and belt line worker, ending in 1989), smoking history (none), and individual history (healthy pulmonary condition until a dramatic deterioration in 1997 with the onset of ALS). Based on his review of the x-ray and CT scan interpretations, Dr. Vuskovich opined that Claimant did not have radiographic evidence of CWP. He also opined that the PFT values from 1989 to 1996 revealed valid, normal spirometry results, and thus, no legal pneumoconiosis. The ABG values he reviewed spanned 1989 through 2002. Dr. Vuskovich found that until 1992, Claimant's musculoskeletal system was intact.

Dr. Vuskovich explained that there is no known cause or cure for ALS. In Claimant's case, the ALS resulted in abrupt respiratory failure which required mechanical ventilation. Also,

he found that the x-ray studies reveal the atelectasis and mucous plugs typical to ALS, which leaves Claimant more susceptible to bacterial invasion and pneumonia. Dr. Vuskovich stated that coal mine employment has not caused or hastened Claimant's ALS, nor did it increase the risk of this disease. He further opined that the evidence does not indicate CWP nor any other pulmonary impairment related to coal dust inhalation. Dr. Vuskovich, however, agreed with Dr. Baker, and concluded that Claimant is totally disabled from a pulmonary perspective due to solely to his ALS.

CT Scans

Dr. Paul Wheeler, a radiologist and B-reader, interpreted the February 20, 2001 and February 26, 2001 CT scans, and submitted a report dated June 1, 2005. (EX 4). Dr. Wheeler determined that the lungs could not be evaluated based on the February 20, 2001 scan because it was an incomplete exam with no lung settings. However, based on the February 26, 2001 scan, he found small, bilateral, posterior, inferior, pleural effusions and discoid atelectasis with subsegmental atelectasis adjacent posterior portion, right lower lobe greater than left lower lobe. He also identified probable minimal emphysema with small areas of decreased and distorted lung markings. Dr. Wheeler concluded that there were no small nodular infiltrates in the mid and upper lungs to suggest CWP, but due to the light lung settings and respiratory motion on several scans, the quality was poor.

Treatment Records

Employer has submitted the following treatment records: University of Kentucky Chandler Medical Center (DX 12); Mary Breckenridge Hospital (DX 13); and Rockcastle Hospital (DX 14). The pertinent[9] treatment records are summarized below in chronological order.

February 1, 1995 – X-ray report by Dr. Patel: Small patchy infiltrate in the left lower lobe and scattered calcified granulomas are noted in both lung fields. (DX 13).

February 1, 1995 – Examination report by Dr. Varghese: Patient presents with chest pain. Examination reveals rhonchi present on both sides and emphysema of the chest. X-ray showed possible lesion on the right apex. (DX 13).

February 3, 1995 – Examination report by Dr. Varghese: Patent worked in the coal mines for 17 years and presents with cough and difficulty breathing. X-ray showed small, patchy infiltrate in the left lower lobe and also granulomatous changes. Sputum is so far negative. Examination revealed emphysematous chest with bilateral rhonchi on both sides and minimal wheezing present. Assessment: pulmonary emphysema with probable black lung. (DX 13).

May 18, 1995 – X-ray report by Dr. Polisetty: Lung fields are clear with no congestion or effusion. No active disease. (DX 13).

[9] Employer's submission includes 200-plus pages without any type of notation or summary of the specific entries of relevance. In addition, most of these reports are handwritten and illegible.

February 20, 2001 – Discharge report by Dr. Lipke: Patient was admitted on the 15th for increasing dyspnea and cough. Patient was thought to have pneumonia as seen by right lower lobe opacity. After treatment, respiratory failure continued, which was presumed to be secondary to ALS. Diagnosis: ALS, respiratory failure, and pneumonia. (DX 12).

February 20, 2001 – X-ray report by Dr. Goldstein: There is opacification of the right lung base which may represent atelectasis. The lungs are otherwise clear. (DX 12).

February 21, 2001 – X-ray report by Dr. Goldstein: Resolving right lower lobe opacity. (DX 12).

February 22, 2001 – X-ray report by Dr. Goodman: Probable bilateral old granulomas appear unchanged. The lungs appear otherwise grossly normal and unchanged. (DX 12).

February 24, 2001 – X-ray report by Dr. Lieber: New infiltrate and probable effusion in the left lower lung. The previously described infiltrate at the right lung base has cleared. (DX 12).

February 26, 2001 – CT scan report by Dr. Kenney: There is no evidence of pulmonary embolism. Increased bilateral lower lobe atelectasis is seen. Obstruction is noted of the bronchus intermedius and left lower lobe bronchi field to be secondary to mucus plug. Borderline mediastinal and bilateral hilar adenopathy is seen which appears unchanged. Resolving right lower lobe opacity. (DX 12).

February 26, 2001 – X-ray report by Dr. Goldstein: There does appear to be further increase in the left lower lung field opacity. There is also a new rounded opacity within the right lower lung field. These findings are most consistent with pneumonia. (DX 12).

February 28, 2001 – X-ray report by Dr. Kenney: opacity is seen at the left lung base consistent with atelectasis or pneumonia. The right lung is clear. (DX 12).

February 28, 2001 – Examination report by Dr. Mishra: X-ray was unremarkable. ABG (charted above). Assessment: Hypoxemia and volume depletion. (DX 13).

March 1, 2001 – X-ray report by Dr. Kenney: Increased left lower lobe opacities are seen consistent with atelectasis or pneumonia. (DX 12).

March 2, 2001 – X-ray report by Dr. Goldstein: There has been interval increase in the left basilar opacity: differential diagnosis includes atelectasis or pneumonia. (DX 12).

March 3, 2001 – X-ray report by Dr. Goodman: Left pulmonary opacity appears grossly unchanged. (DX 12).

March 4, 2001 – X-ray report by Dr. Goodman: Opacity overlying the left heart appears grossly unchanged and likely represents left lower lobe alveolar opacity. (DX 12).

March 12, 2001 – X-ray report by Dr. Goldstein: Mild left lower lobe atelectasis or pneumonia is seen. Lungs are otherwise clear. (DX 12).

March 13, 2001 – X-ray report by Dr. King: Ill-defined consolidation is noted in the left lower lung and may represent atelectasis or pneumonia. (DX 12).

March 14, 2001 – X-ray report by Dr. Goldstein: Increased perihilar opacities are present. These findings likely represent worsening pulmonary edema. (DX 12).

March 14, 2001 – Examination report by Dr. McElwain: Patient has been suffering from what appears to be ACS but refuses additional testing. He developed pneumonia in February 2001 with subsequent respiratory failure. Lungs are clear to auscultation. Assessment: ventilator dependant secondary to ALS. (DX 14).

April 13, 2001 – Consultation report by Dr. Buch: He has fair air on both sides with no rales, rhonchi, or wheezes. Impression: Chronic respiratory failure secondary to neuromuscular weakness, presumed to be ALS. (DX 14).

June 10, 2001 – X-ray report by Dr. Dineen: Left basilar and right middle lobe atelectasis, which has increased somewhat since the previous exam. (DX 14).

June 10, 2001 – X-ray report by Dr. Reed: Bibasilar opacification is noted and atelectasis is favored over pneumonia. (DX 12).

June 11, 2001 – X-ray report by Dr. Reed: There has been interval increase in bibasilar opacification consistent with worsening atelectasis or pneumonia. (DX 12).

June 12, 2001 – X-ray report by Dr. Reed: There has been interval increase in bilateral lower lobe patchy opacities, most consistent with atelectasis and pulmonary edema. There is probable bilateral pleural fluid collections. (DX 12).

June 13, 2001 – X-ray report by Dr. King: There are persistent bilateral pleural effusions and increasing right medial focal consolidation consistent with worsening pneumonia. (DX 12).

June 14, 2001- Discharge report by Dr. Burki: Examination revealed good air movement and coarse breath sounds bilaterally, which were worse at the right base. ABG (charted above). (DX 12).

PREVIOUSLY SUBMITTED MEDICAL EVIDENCE

I incorporate by reference, as if fully set forth herein, the medical evidence contained in the April 21, 1994 decision and order denying benefits issued by Administrative Law Judge O'Neill, which was affirmed by the Benefits Review Board on January 24, 1995, and the November 26, 1996 decision and order on modification denying benefits by Judge O'Neill, which was affirmed by the Board on November 24, 1997. Employer has not disagreed with the factual summaries provided by Judge O'Neill, but instead has argued that the newly submitted

evidence does not support a finding of a material change in condition. Judge O'Neill completely and thoroughly summarized the relevant medical evidence of record from the time Claimant filed his claim until the decision and order in November 1996. Therefore, I will not disturb the factual descriptions of the original evidence, but will refer to it as necessary to resolve the modification issue now before me.

Smoking History

Claimant's responses to Employer's interrogatories noted that he previously smoked, but that he could not remember the dates. (DX 15a). All of the physicians' reports, however, note that Claimant is a non-smoker. Therefore, since there is no documented smoking history, I find that Claimant is a life-long non-smoker.

DISCUSSION AND APPLICABLE LAW

Mr. Barrett's claim was made after March 31, 1980, the effective date of Part 718, and must therefore be adjudicated under those regulations. To establish entitlement to benefits under Part 718, Claimant must establish, by a preponderance of the evidence, that he:

1. Is a miner as defined in this section; and

2. Has met the requirements for entitlement to benefits by establishing that he:

   (i) Has pneumoconiosis (see § 718.202), and

   (ii) The pneumoconiosis arose out of coal mine employment (see § 718.203), and

   (iii) Is totally disabled (see § 718.204(c)), and

   (iv) The pneumoconiosis contributes to the total disability (see § 718.204(c)); and

3. Has filed a claim for benefits in accordance with the provisions of this part.

Section 725.202(d)(1-3); *see also* §§ 718.202, 718.203, and 718.204(c).

Subsequent Claim

The provisions of § 725.309 apply to new claims that are filed more than one year after a prior denial. Section 725.309 is intended to provide claimants relief from the ordinary principles of *res judicata*, based on the premise that pneumoconiosis is a progressive and irreversible disease. *See Lukman v. Director, OWCP*, 896 F.2d 1248 (10th Cir. 1990); *Orange v. Island Creek Coal Company*, 786 F.2d 724, 727 (6th Cir. 1986); § 718.201(c) (Dec. 20, 2000). The amended version of § 725.309 dispensed with the material change in conditions language and implemented a new threshold standard for the claimant to meet before the record may be reviewed *de novo*. Section 725.309(d) provides that:

> If a claimant files a claim under this part more than one year after the effective date of a final order denying a claim previously filed by the claimant under this part, the later claim shall be considered a subsequent claim for benefits. A subsequent claim shall be processed and adjudicated in accordance with the provisions of subparts E and F of this part, except that the claim shall be denied unless the claimant demonstrates that one of the applicable conditions of entitlement (see § 725.202(d) miner. . .) has changed since the date upon which the order denying the prior claim became final. The applicability of this paragraph may be waived by the operator or fund, as appropriate. The following additional rules shall apply to the adjudication of a subsequent claim:
>
> (1) Any evidence submitted in conjunction with any prior claim shall be made a part of the record in the subsequent claim, provided that it was not excluded in the adjudication of the prior claim.
>
> (2) For purposes of this section, the applicable conditions of entitlement shall be limited to those conditions upon which the prior denial was based. For example, if the claim was denied solely on the basis that the individual was not a miner, the subsequent claim must be denied unless the individual worked as a miner following the prior denial. Similarly, if the claim was denied because the miner did not meet one or more of the eligibility criteria contained in part 718 of the subchapter, the subsequent claim must be denied unless the miner meets at least one of the criteria that he or she did not meet previously.
>
> (3) If the applicable condition(s) of entitlement relate to the miner's physical condition, the subsequent claim may be approved only if new evidence establishes at least one applicable condition of entitlement. . . .
>
> (4) If the claimant demonstrates a change in one of the applicable conditions of entitlement, no findings made in connection with the prior claim, except those based on a party's failure to contest an issue, shall be binding on any party in the adjudication of the subsequent claim. However, any stipulation made by any party in connection with the prior claim shall be binding on that party in the adjudication of the subsequent claim.

Section 725.309(d) (April 1, 2002).

Claimant's prior claim was denied after it was determined that he failed to establish any of the elements of entitlement. (DX 1). Consequently, the Claimant must establish, by a preponderance of the newly submitted evidence, at least one applicable condition of entitlement previously adjudicated against him. If Claimant is able to show that he has pneumoconiosis, that this pneumoconiosis arose out of coal mine employment, or that he is totally disabled as a result of pneumoconiosis, then he will avoid having his subsequent claim denied on the basis of the prior denial.

Total Disability

Claimant may establish a material change in conditions by demonstrating that he is totally disabled from performing his usual coal mine work or comparable work due to pneumoconiosis under one of the five standards of § 718.204(b) or the irrebuttable presumption referred to in § 718.204(b). The Board has held that under § 718.204(b), all relevant probative evidence, both like and unlike must be weighed together, regardless of the category or type, in the determination of whether the Claimant is totally disabled. *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195 (1986); *Rafferty v. Jones & Laughlin Steel Corp.*, 9 B.L.R. 1-231 (1987). Claimant must establish this element of entitlement by a preponderance of the evidence. *Gee v. W.G. Moore & Sons*, 9 B.L.R. 1-4 (1986).

The record does not include any evidence that Claimant suffers from complicated pneumoconiosis. Therefore, the irrebuttable presumption of § 718.304 does not apply.

Total disability can be shown under § 718.204(b)(2)(i) if the results of pulmonary function studies are equal to or below the values listed in the regulatory tables found at Appendix B to Part 718. The newly submitted evidence does not include any PFT values. Therefore, § 718.204 (b)(2)(i) does not apply.

Total disability can be demonstrated under § 718.204(b)(2)(ii) if the results of arterial blood gas studies meet the requirements listed in the tables found at Appendix C to Part 718. The newly submitted ABG studies are inconsistent. Only three of the ten associated with Claimant's February 2001 hospitalization were qualifying, none of the seven studies associated with his March 2001 hospitalization were qualifying, all five of the studies in connection with his June 2001 hospitalization were qualifying, and the August 12, 2002 study was qualifying. I note, however, that the most recent study was conducted on supplemental oxygen.

In *Jeffries v. Director, OWCP*, 6 B.L.R. 1-1013 (1984), the Board held as follows regarding probative value of blood gas and ventilatory studies conducted during the miner's hospitalization for a heart attack:

> The Director contends that, because the studies were performed during claimant's hospitalization for a heart attack, they are unreliable and cannot support invocation. Although this argument is very appealing, we decline to accept it in this case. While the studies may have been affected by claimant's heart attack, and may, therefore, actually be unreliable, without qualified medical testimony to that effect, neither the Board nor the administrative law judge has the requisite medical expertise to make that judgment. The Director has produced no such evidence.

Id. at 1-1014. *But see Hess v. Director, OWCP*, 21 B.L.R. 1-141 (1998) (it was proper for the administrative law judge to question the reliability of a blood gas study where a physician stated that it was taken while Claimant was in the hospital and "may not be representative of [claimant's] true lung function").

While the ABG studies conducted during hospitalization may not truly reflect Claimant's ability to transfer oxygen, based on *Jeffries*, I do not possess the "requisite medical expertise to make that judgment." In addition, unlike *Hess*, with exception of the August 2002 study, there is no physician's statement casting doubt on the reliability of the remainder of the studies. As a result, I find that the most recent ABG evidence of record produced values that meet the requirements of the tables found at Appendix C to Part 718. Therefore, I find that Claimant has established the existence of total disability under subsection (b)(2)(ii).

Total disability may also be shown under § 718.204(b)(2)(iii) if the medical evidence indicates that Claimant suffers from cor pulmonale with right-sided congestive heart failure. The record does not contain any evidence indicating that Claimant suffers from cor pulmonale with right-sided congestive heart failure. Therefore, I find that Claimant has failed to establish the existence of total disability under subsection (b)(2)(iii).

Section 718.204(b)(2)(iv) provides for a finding of total disability if a physician, exercising reasoned medical judgment based on medically acceptable clinical or laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevented the miner from engaging in his usual coal mine employment or comparable gainful employment. Claimant's last coal mine employment as a rock duster and shoveling coal required that he stand for eight to twelve hours per day and lift 50 to 75 pounds several times per day. (DX 4).

The exertional requirements of the claimant's usual coal mine employment must be compared with a physician's assessment of the claimant's respiratory impairment. *Cornett v. Benham Coal, Inc.*, 227 F.3d 569 (6th Cir. 2000). Once it is demonstrated that the miner is unable to perform his usual coal mine work, a *prima facie* finding of total disability is made and the party opposing entitlement bears the burden of going forth with evidence to demonstrate that the miner is able to perform "comparable and gainful work" pursuant to § 718.204(b)(1). *Taylor v. Evans & Gambrel Co.*, 12 B.L.R. 1-83 (1988). Nonrespiratory and nonpulmonary impairments have no bearing on establishing total disability due to pneumoconiosis. § 718.204(a); Jewell *Smokeless Coal Corp. v. Street*, 42 F.3d 241 (1994). All evidence relevant to the question of total disability due to pneumoconiosis is to be weighed, with the claimant bearing the burden of establishing by a preponderance of the evidence the existence of this element. *Mazgaj v. Valley Camp Coal Co.*, 9 B.L.R. 1-201 (1986).

Drs. Baker, Broudy, and Vuskovich unanimously opined that Claimant was totally disabled from a pulmonary perspective due to ALS. These physicians all considered the exertional requirements of Claimant's last coal mine employment, and the fact that he was undergoing mechanical ventilation due to abrupt respiratory failure. As a result, I find these opinion to be adequately based on the objective evidence, and thus, well-reasoned and well-documented. Therefore, I accord Drs. Baker, Broudy, and Vuskovich's opinions probative weight.

The newly submitted medical opinion evidence includes three well-reasoned and well-documented reports concluding that Claimant is totally disabled from a pulmonary standpoint. Since there are no contrary opinions, I find that Claimant has proven by a preponderance of the newly submitted evidence that he suffers from a total pulmonary disability under § 718.204(b)(2)(iv).

Considering the newly submitted medical evidence, Claimant has successfully established total pulmonary disability under subsection (b)(2)(ii) and (iv). In addition, even without the ABG evidence, I find the unanimous medical opinions to be the most probative. I further note that Employer does not contest this issue. Therefore, after weighing all of the newly submitted evidence concerning total disability together under §718.204 (b)(2), I find that the record supports Employer's concession of this issue, and find that Claimant has established by a preponderance of the evidence that he is totally disabled from a respiratory standpoint.

I have determined that Claimant has total respiratory disability by the newly submitted evidence under §718.204 (b)(2). Comparing these findings to the previously submitted evidence, I note that none of the earlier PFT or ABG studies were qualifying under the regulations. In addition, the only medical opinion from the previously submitted record to conclude that Claimant was totally disabled was that by Drs. Varghese, which I found to be poorly reasoned and documented in the timeliness discussion above, and thus, insufficient for the purpose of proving total disability due to pneumoconiosis. On the other hand, the previously submitted reports by Drs. Wicker, Vuskovich, Wright, and Deneen all opined that Claimant was not totally disabled from performing his usual coal mine employment. As a result, I find that the preponderance of the previously submitted evidence was insufficient to establish that Claimant was totally disabled, and thus, I find that the newly submitted evidence is qualitatively different from the previously submitted medical evidence. Therefore, considering all of the evidence of record, I find that Claimant has established a material change in his physical condition by proving total pulmonary disability under §718.204(b)(2). Claimant's modification request will not be denied on the basis of the prior denial. In order to receive benefits, Claimant must now satisfy the remaining requirements of §718, considering both the old and new evidence.

Pneumoconiosis

Claimant has the burden of proving the existence of pneumoconiosis, as well as every element of entitlement, by a preponderance of the evidence. *See Director, OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994).

Pneumoconiosis is defined by the regulations:

> (a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical" pneumoconiosis and statutory, or "legal" pneumoconiosis.
>
> (1) *Clinical Pneumoconiosis*. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, i.e.,

> conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
>
> (2) *Legal Pneumoconiosis*. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.
>
> (b) For the purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.
>
> (c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

Sections 718.201(a-c).

Section 718.202(a) sets forth four methods for determining the existence of pneumoconiosis.

(1) Under § 718.202(a)(1), a finding that pneumoconiosis exists may be based upon x-ray evidence. Because pneumoconiosis is a progressive disease, I may properly accord greater weight to the interpretations of the most recent x-rays, especially where a significant amount of time separates the newer from the older x-rays. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (en banc); *Casella v. Kaiser Steel Corp.*, 9 B.L.R. 1-131 (1986). I may also assign heightened weight to the interpretations by physicians with superior radiological qualifications. *See McMath v. Director, OWCP*, 12 B.L.R. 1-6 (1988); *Clark*, 12 B.L.R. 1-149 (1989).

Considering the previously submitted evidence, based on the "uniformly negative readings" by dually certified physicians, Judge O'Neill determined that the preponderance of the x-ray evidence was negative for pneumoconiosis. This conclusion was also affirmed by the Board. I have reviewed these interpretations, and find that Judge O'Neill's determination is supported by substantial evidence. In addition, due to the fact that these films are all at least five years older than the newly submitted readings, I find that they are entitled to less weight.

The newly submitted evidence includes three interpretations of two chest x-rays.[10] Dr. Baker, a B-reader, interpreted the September 14, 2001 x-ray as positive for pneumoconiosis. Dr. Scott, a radiologist and B-reader, read the film as negative. Based on Dr. Scott's superior qualifications, I find the September 14, 2001 film to be negative for pneumoconiosis.

Dr. Broudy, a B-reader, interpreted the August 27, 2002 x-ray as negative for pneumoconiosis. There were no contradictory interpretations. Therefore, I find that the August 27, 2002 film is negative for the existence of pneumoconiosis.

I have determined that the most recently submitted x-ray evidence is more probative than the previously submitted readings, and that both of these films are negative for pneumoconiosis. Therefore, I find that Claimant has failed to prove by a preponderance of the evidence under subsection (a)(1) that he suffers from pneumoconiosis.

(2) Under § 718.202(a)(2), a determination that pneumoconiosis is present may be based, in the case of a living miner, upon biopsy evidence. The evidentiary record does not contain any biopsy evidence. Therefore, I find that the Claimant has failed to establish the existence of pneumoconiosis through biopsy evidence under subsection (a)(2).

(3) Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of several cited presumptions are found to be applicable. In this case, the presumption of § 718.304 does not apply because there is no evidence in the record of complicated pneumoconiosis. Section 718.305 is not applicable to claims filed after January 1, 1982. Finally, the presumption of § 718.306 is applicable only in a survivor's claim filed prior to June 30, 1982. Therefore, Claimant cannot establish pneumoconiosis under subsection (a)(3).

(4) The fourth and final way in which it is possible to establish the existence of pneumoconiosis under § 718.202 set forth in subsection (a)(4) which provides in pertinent part:

> A determination of the existence of pneumoconiosis may also be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical

[10] Included in the treatment notes are several radiology reports by a variety of physicians. There is no evidence in the record as to the x-ray reading credentials of these physicians. §718.102(c). Also, these interpretations were all related to the treatment of Claimant's condition, and not for the purpose of determining the existence or extent of pneumoconiosis. In addition, there is no record of the film quality for any of these x-rays. §718.102(b). Finally, the interpreting physicians did not provide an ILO classification for their readings. §718.102(b). These x-ray interpretations are not in compliance with the quality standards of §718.102 and Appendix A to Part 718. Also, Employer designated Dr. West's August 27, 2002 interpretation as initial evidence. While it is not readily apparent whether Dr. West's interpretation was performed in conjunction with medical treatment, it is clear that is suffers from many of the same deficiencies as the treatment readings. In addition, I note that Dr. West does not affirmatively state or deny whether the August 27, 2002 film shows the existence of pneumoconiosis. Therefore, I accord the x-ray interpretations contained in the treatment records, and Dr. West's August 27, 2002 interpretation, no weight for the purpose of determining whether Claimant suffers from pneumoconiosis under § 718.202(a)(1).

and work histories. Such a finding shall be supported by a reasoned medical opinion.

§ 718.202(a)(4).

This section requires a weighing of all relevant medical evidence to ascertain whether or not the claimant has established the presence of pneumoconiosis by a preponderance of the evidence. Any finding of pneumoconiosis under § 718.202(a)(4) must be based upon objective medical evidence and also be supported by a reasoned medical opinion. A reasoned opinion is one which contains underlying documentation adequate to support the physician's conclusions. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts, and other data on which he bases his diagnosis. *Oggero v. Director, OWCP*, 7 B.L.R. 1-860 (1985). A brief and conclusory medical report which lacks supporting evidence may be discredited. *See Lucostic v. United States Steel Corp.*, 8 B.L.R. 1-46 (1985); *see also*, *Mosely v. Peabody Coal Co,.* 769 F.2d 257 (6th Cir. 1985). Further, a medical report may be rejected as unreasonable where the physician fails to explain how his findings support his diagnosis. *See Oggero*, 7 B.L.R. 1-860. Finally, a medical report containing the most recent physical examination of the miner may be properly accorded greater weight as it is likely to contain a more accurate evaluation of the miner's current condition. *Gillespie v. Badger Coal Co.*, 7 B.L.R. 1-839 (1985). *See also Bates v. Director, OWCP*, 7 B.L.R. 1-113 (1984) (more recent report of record entitled to more weight than reports dated eight years earlier); *Kendrick v. Kentland-Elkhorn Coal Co.*, 5 B.L.R. 1-730 (1983).

In the 1994 decision and order, Judge O'Neill determined that the preponderance of the medical opinion evidence did not support a finding of pneumoconiosis. He based this determination on the fact that Drs. Wicker, Wright, and Anderson, who all diagnosed the disease, did so based primarily on positive x-ray interpretations. Like Judge O'Neill, I have found that Claimant has not proven the existence of pneumoconiosis by x-ray evidence. In addition, Judge O'Neill determined that the remainder of the medical opinions diagnosing pneumoconiosis failed to adequately explain the basis for these findings in light of the non-qualifying PFT and ABG studies. As a result, he found these opinions to be "unreasoned, undocumented, and unsupported by the objective medical evidence, … [and thus,] insufficient to establish pneumoconiosis." On modification Judge O'Neill found Dr. Varghese's diagnosis of pneumoconiosis to be unreasoned and contradicted by the rest of the medical evidence, which is consistent with my findings concerning this report. The Board affirmed Judge O'Neill's conclusions. I have reviewed these reports and find that Judge O'Neill's conclusions are supported by substantial evidence. However, since the newly submitted medical opinions consider evidence developed more than five years since those considered by Judge O'Neill, I find that the newly submitted evidence is more probative than that previously considered.

Dr. Baker considered accurate coal mine employment and smoking histories, an x-ray, and a physical examination. Dr. Baker's diagnosis of CWP, however, was based solely on a chest x-ray and coal dust exposure. The Sixth Circuit Court of Appeals, however, has held that merely restating an x-ray is not a reasoned medical judgment under § 718.202(a)(4). *Cornett v. Benham Coal, Inc*., 227 F.3d 569 (6th Cir. 2000). Therefore, I find that Dr. Baker's diagnosis of

clinical pneumoconiosis is not a reasoned opinion under subsection (a)(4). In addition, the only other pulmonary condition Dr. Baker diagnosed was ALS, which he did not attribute to any specific cause. Thus, I find that Dr. Baker has not provided a diagnosis of legal pneumoconiosis.

Drs. Broudy and Vuskovich both concluded that the objective evidence of record did not support a finding of pneumoconiosis, but instead, that Claimant's respiratory condition was solely the result of ALS. In addition, they both emphasized that there is no known cause of ALS, and no medical literature linking this condition to the inhalation of coal dust. Thus, they opined that Claimant does not suffer from pneumoconiosis. I find that Drs Broudy and Vuskovich's opinions are adequately supported by the objective evidence of record, and are thus well-reasoned and well-documented. Therefore, I accord their opinions probative weight.

I next find that Dr. Wheeler's negative interpretation of the February 26, 2001 CT scan to be probative, based in part, on his exceptional qualifications as a radiologist and B-reader. However, due to his quality determination, I accord his opinion less weight.

Finally, considering the treatment notes, I find that Dr. Varghese's February 1995 entry was the only diagnosis of pneumoconiosis to be included in the new evidence. Based on accurate coal mine employment, symptomatology, an x-ray, and a physical examination, Dr. Varghese opined that Claimant suffered from the disease. While his report is adequately based on the objective evidence he considered, and thus, well-reasoned and well-documented, I accord it less weight that the reports by Drs. Broudy and Vuskovich. Drs. Broudy and Vuskovich's reports considered evidence that was several years more recent than that considered by Dr. Varghese. *Gillespie*, 7 B.L.R. 1-839. Furthermore, Dr. Varghese did not discuss the existence of ALS.[11] Therefore, while I find Dr. Varghese's 1995 diagnosis of pneumoconiosis to be probative, I accord his opinion less weight than I do the opinions by Drs. Broudy and Vuskovich.

I have found that the medical opinions by Drs. Broudy and Vuskovich to be entitled to the most probative weight. Therefore, considering all of the evidence of record, both new and old, I find that Claimant has failed to prove by a preponderance of the evidence that he suffers from pneumoconiosis under subsection (a)(4).

Considering all of the evidence of record, Claimant has failed to establish the existence of pneumoconiosis under subsection (a)(1)-(4). Therefore, after considering all evidence of pneumoconiosis together under §718.202(a), I find that Claimant has failed to prove by a preponderance of the evidence that he suffers from pneumoconiosis.

Arising out of Coal Mine Employment and Total Disability Due to Pneumoconiosis

Because Claimant has failed to establish the existence of pneumoconiosis, the question of whether it was cause by coal mine employment is moot. Similarly, since Claimant does not suffer from pneumoconiosis, then it is not possible that his total disability is due to

[11] In fairness, I note that the record reflects that ALS was not diagnosed until sometime in 1995 or 1996. As a result, Dr. Varghese probably did not know that Claimant suffered from this condition. While this omission does not undermined that reasonableness of his opinion, I find that it does greatly diminish the comparative weight that can be accorded to his conclusions.

pneumoconiosis. Therefore, I find that the evidence of record fails to establish either of these elements of entitlement.

Entitlement

The Claimant, Mr. Barrett, has established a material change in conditions sufficient to meet the statutory requirements of § 725.309(d). However, considering both the previously submitted and newly submitted medical evidence, he failed to prove that he has pneumoconiosis arising from coal mine employment, or that his total disability is due to pneumoconiosis. Therefore, Mr. Barrett is not entitled to benefits under the Act.

Attorney's Fees

An award of attorney's fees is permitted only in cases in which the claimant is found to be entitled to benefits under the Act. Because benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for the representation and services rendered in pursuit of the claim.

ORDER

IT IS ORDERED that the claim of Joe Barrett for benefits under the Act is hereby DENIED.

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THOMAS F. PHALEN, JR.
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board. After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. §

725.481. If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).